



# LETTERS

## DEXMETOMIDINE AS A SOLE SEDATING AGENT WITH LOCAL ANESTHESIA IN A HIGH RISK PATIENT FOR AXILLOFEMORAL BYPASS GRAFT

### To the editor:

The case report "Dexmedetomidine as a sole sedating agent with local anesthesia in a high risk patient for axillofemoral bypass graft"<sup>1</sup> provided an interesting clinical scenario with a well-described intraoperative course. While there are anecdotal reports of dexmedetomidine use as a sole sedating agent with local anesthesia, this case report provides a needed contribution to the anesthesia literature on this topic.

One point I would like to clarify is the warning posted on the Hospira website: "Caution should be exercised when administering Precedex to patients with advanced heart block and/or severe ventricular dysfunction."<sup>2</sup> The patient in the case report had a reported left ventricular ejection fraction of 35% and clearly tolerated dexmedetomidine well. However, since the manufacturer advises caution with administration of this drug to patients with ventricular dysfunction, readers need to be aware that administration of dexmedetomidine may carry additional risk in patients with compromised left ventricular function.

### REFERENCES

1. Rich JM. Dexmedetomidine as a sole sedating agent with local anesthesia in a high risk patient for axillofemoral bypass graft: A case report. *AANA J*. 2005;73:357-360.
2. Precedex. Hospira website. 2005. Available at: <http://precedex.hospira.com/default.aspx>. Accessed November 8, 2005.

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### Response:

I thank Dr Kremer for pointing out the Hospira labeling information concerning use of dexmedetomidine in patients with advanced heart block and/or severe ventricular dysfunction. This reinforces the need for careful patient selection and vigilant perioperative monitoring when using this  $\alpha_2$  agonist. On an additional note, the cardioprotective function of  $\alpha_2$  agonists in high risk cardiac patients undergoing noncardiac surgery has now been established.<sup>1</sup>

### REFERENCE

1. Wallace A, Galindez D, Salahieh A, et al. Effect of clonidine on cardiovascular morbidity and mortality after noncardiac surgery. *Anesthesiology*. 2004;101:284-293.

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## THE CERTIFIED REGISTERED NURSE ANESTHETIST: OCCUPATIONAL RESPONSIBILITIES, PERCEIVED STRESSORS, COPING STRATEGIES, AND WORK RELATIONSHIPS

### To the editor:

I read with great interest the *AANA Journal* article, "The Certified Registered Nurse Anesthetist: Occupational responsibilities, perceived stressors, coping strategies, and work relationships."<sup>1</sup> While I found the article informing and well presented, I feel insufficient attention was directed toward the following 2 issues.

First, the workload found in today's operating room (OR) and ancillary areas coupled with the very palpable production pressure causes most anesthesia providers to feel pushed to the extent that they don't feel they have an adequate opportunity to review a patient's

pertinent history before providing the anesthetic. In addition, the opportunity to develop rapport with the patient also is severely limited resulting on many occasions in undue stress to the patient and his or her family. In the postanesthesia care unit (PACU), as well, the pressure to "turn over" cases means that less time is afforded to follow up on patients' immediate postoperative needs.

Second, the anesthesia providers are often unable to find the time for breaks or lunch unless a break in schedule occurs. These providers are expected to function at peak levels of concentration working 8 hours or longer without lunch or a break. I have, as a locum tenens CRNA, seen with my own eyes other providers eating lunch at the anesthesia machine or at the doorway leading into the operating room while caring for the patient.

Now, in all fairness, these issues are very rare in settings where staffing is sufficiently adequate as to provide for staff to evaluate patients preoperatively, in the PACU, as well as follow-up postoperatively. This staff also would provide breaks and lunches to the providers in the OR and be available for emergencies in the OR and ancillary areas. Unfortunately, such staffing levels are rarely met in smaller, rural settings resulting in abuse of the anesthesia providers and less than comprehensive care for their patients.

I have provided anesthesia services for 28 years and I see these problems becoming more prevalent each year. This letter is an indictment to the present state of healthcare in the operating rooms of our smaller, rural hospitals; surgicenters; and office-based surgical suites.

### REFERENCE

1. Perry TR. The Certified Registered Nurse Anesthetist: Occupational responsibilities, perceived stressors, coping strategies, and work relationships. *AANA J*. 2005;73:351-356.

**Abraham J. Lachman, CRNA**  
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### Response

Mr Abraham J. Lachman, CRNA, expresses valid points. These were

addressed in my complete PhD dissertation, but due to *AANA Journal* publication limitations and requests, all issues and pertinent factors relating to nurse anesthetists' perceived and real stressors could not be fully elaborated upon in this brief composition.

I agree with Mr Lachman and as I stated in credits at the end of my article, my mother, Nancy Roberts, has been a CRNA since 1973 and has expounded on these problems. I grew up around nurse anesthetists as many were, and are, family friends and have heard every conceivable scenario imaginable. These include a time when my mother worked all day from 7 AM to 3:30 PM in a busy operating room, then went on call at 3:30 PM and worked straight through until 1:30 AM the next morning. The 3:30 PM until 1:30 AM shift did not include any meals or breaks of any kind. She had no anesthesia technician or anesthesiologist or any other ancillary support. When she arrived home at 2 AM, she got a bite to eat, took a shower, tried to unwind, and retired to bed at 3:30 AM.

Consequently, with only a few hours of restless sleep and a severe headache, she called in sick for the 7 AM to 3:30 PM shift. The custom in this particular anesthesia department was if a CRNA worked past midnight, he/she did not report the next day. The chief surgeon at this time walked into the operating room where she was assigned the day following her calling in sick and liter-

ally lambasted her in front of a room full of surgeons, students, nurses, technicians, etc, for not reporting in after working 18.5 hours. This all the while she was administering anesthesia on a patient undergoing an abdominal aortic aneurysm resection/grafting. He told her he "did not care how many hours she worked, she was to be there."

Of interest, the chief CRNA offered my mother no support and certainly did not discuss the chief of surgery's positions or actions with him. How do CRNAs then address these stressors? One point I mention is that while the document certainly does point out stressors: The intent was to not specifically root out causing agents—only to emphasize that they do exist, should be recognized, and dealt with individually by CRNAs. Hopefully, more investigation can be conducted to determine how best to confront them from business, corporate, and organizational (ie, American Association of Nurse Anesthetists, American Society of Anesthesiologists) viewpoints and face these standard operating procedures and archaic attitudes that have been *accepted for so long and allowed to occur*.

I thank Mr Lachman for his comments. My full dissertation can be read at this website: <http://scholar.lib.vt.edu/theses/available/etd-11252002-111750/>.

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### Authors' Clarification

In our October 2005 *AANA Journal* article, "A national survey of Certified Registered Nurse Anesthetists' knowledge, beliefs, and assessment of herbal supplements in the anesthesia setting" (2005;73:368-377), we published a questionnaire (Figure 1) that included a knowledge quiz on common herbal supplements, but we did not include the answers to the knowledge quiz. Some CRNAs who were testing their own knowledge contacted us for the correct answers, and we would like to provide the answers for others who may be interested. For questions 38 to 53, here are the correct answers:

38. Echinacea
39. Garlic
40. Ginseng
41. Kava kava
42. St John's wort
43. Valerian root
44. Ephedra
45. Echinacea
46. Ginkgo biloba
47. Garlic
48. Ginseng
49. St John's wort
50. Valerian root
51. Ginkgo biloba
52. Kava kava
53. Ephedra

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